PATIENT REGISTRATION

Throughout this registration form, "Medical Group" includes WellMed Medical Group, PA; WellMed Medical Management of Florida, Inc.; OptumCare Florida Inc.; USMD Physician Services, Inc. ("USMD"); and Healthcare Associates of Irving ("HCAT").

Patient name: _____ Birth date (MM/DD/YYYY): _____

Street address: _____ City/State/Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____

Preferred pharmacy: _____ Address:_____ Phone:_____

Preferred spoken medical language: ☐ English ☐ Spanish ☐ Other: _____

Preferred written medical language: ☐ English ☐ Spanish ☐ Other: _____

Do you require translation (written/verbal) services? ☐ Yes ☐ No ☐ Language: _____

Do you ever need help understanding the medical information you receive from your provider/staff? ☐ Yes ☐ No

Race: ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White

☐ American Indian or Alaska Native ☐ Prefer not to report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to report Sex: ☐ M ☐ F ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally separated

Are you a Medical Group employee or family member of a Medical Group employee ? ☐ Yes ☐ No

PREFERRED CONTACTS (List those who you wish to be involved in your care.)

Name	Relationship to patient		Phone number
	☐ Parent ☐ Child ☐ Spouse ☐ Other _____ _____	☐ Emergency contact ☐ Guardian ☐ HIPAA*	Home: _____ Work: _____ Cell: _____
	☐ Parent ☐ Child ☐ Spouse ☐ Other _____ _____	☐ Emergency contact ☐ Guardian ☐ HIPAA*	Home: _____ Work: _____ Cell: _____
	☐ Parent ☐ Child ☐ Spouse ☐ Other _____ _____	☐ Emergency contact ☐ Guardian ☐ HIPAA*	Home: _____ Work: _____ Cell: _____

***By checking the HIPAA box, I authorize Medical Group to discuss my/the patient's care and medical needs with the contact listed.**

_____**Patient/Parent or Legal Guardian Initials**

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. We provide free services to help you communicate with us such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-888-781-WELL (9355). ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-888-781-WELL (9355). 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-888-781-WELL (9355)。

Patient Name_____

AUTHORIZATION TO WEB-ENABLE FOR PATIENT PORTAL (Only one email may be used per patient account.)
By checking the box below and providing an email, I authorize Medical Group to web-enable my account using the email provided to register for Patient Portal so that for access and review my health records and medications, communicate with my clinic, and receive clinic-related notifications such as appointment reminders, using:

☐ My email: _____ ☐ My Proxy's* email: _____

***Proxy must be listed in Preferred Contacts with HIPAA box checked to web enable for Proxy Access to Patient Portal. It is recommended that you provide a private email address to which only you/your Proxy has access.**

_____ **Patient or Parent/Legal Guardian Initials**

CONSENT TO TREAT

I voluntarily consent to receive medical and health care services provided by Medical Group physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatments. I understand that Medical Group is an affiliated teaching site and may have residents and students involved in my care. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend or receive services from Medical Group.

_____**Patient or Parent/Legal Guardian Initials**

AUTHORIZATION TO RECEIVE PRESCRIPTION HISTORY

I authorize Medical Group and its Affiliated Providers to electronically retrieve my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand that Medical Group and its Affiliated Providers will use my external prescription history to provide me with medical treatment and to evaluate and improve patient safety and the quality of medical care. I understand that I can revoke my permission at any time by giving written notice to my provider.

_____**Patient or Parent/Legal Guardian Initials**

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION WITHIN MEDICAL GROUP

I understand and agree that: This authorization is voluntary; My Protected Health Information (PHI) may contain information created by others, including health care providers, may include medical, pharmacy, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information, and may include, for example, information relating to visits, admissions, treatment, claims, case management or care coordination; I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not initial this section; The PHI I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws; I authorize Medical Group and its affiliates to access, use and disclose my individually identifiable PHI between themselves, and authorize my treating providers (past, present, future) to use and disclose my individually identifiable PHI with Medical Group and its affiliates. This authorization remains in effect unless and until I revoke it; I may revoke this authorization at any time by notifying Medical Group in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed. I understand that consistent with 42 CFR Part 2, I have a right upon my request to be provided a list of entities to which my PHI has been disclosed pursuant to this general designation.

_____**Patient or Parent/Legal Guardian Initials**

Patient Name_____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION TO HEALTH INFORMATION EXCHANGES (HIES) AND INTEROPERABILITY EXCHANGES

I understand and agree that: This authorization is voluntary; I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not initial this section; Greater Houston Healthconnect (www.ghhconnect.org), Carequality (https://carequality.org), Commonwell (www.commonwellalliance.org/providers) and any future HIEs to which Medical Group connects and their current and future participants may access, use, and disclose my Protected Health Information (PHI) electronically through the exchanges for the purposes of treatment, payment, and health care operations; These entities may connect to other HIEs across the country and I authorize these entities to access, use, and disclose my information with those exchanges for the same treatment, payment, and health care operation purposes; My PHI, including notes, test results, lab reports, x-rays, medication lists, or any other relevant electronic PHI may be shared through these exchanges; My PHI may be subject to re-disclosure by the recipient entities, and if those recipients are not health care providers or health plans, the information may no longer be protected by the federal privacy regulations; This authorization remains in effect unless and until I revoke it; I may revoke this authorization at any time by giving written notice to Medical Group; and I understand that revoking this authorization will not have an effect on any actions taken prior to the date my revocation is received and processed.

_____**Patient or Parent/Legal Guardian Initials**

CONSENT FOR DIGITAL COMMUNICATIONS

By providing my telephone number to Medical Group, I agree to receive automated calls, prerecorded messages, and/or voice or text messages related to my health care from Medical Group and its affiliates. I agree to receive text message appointment reminders and clinic-related notifications, such as flu shot availability or closures, on the phone number. I understand that message and data rates may apply, terms and privacy information are available online (www.wellmedhealthcare.com/texting-terms) and that messages will be recurring. I also acknowledge and agree that these text messages may contain Protected Health Information (PHI). Text messaging is not a secure method of communication and carries some risk of being read by a third party. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing.

_____**Patient or Parent/Legal Guardian Initials**

CONSENT FOR PHOTOGRAPHY AND VIDEO/AUDIO RECORDING

I consent to Medical Group taking my image for use in treatment, payment or for health care operations. I understand that my image, including photographs and audio/video recordings, will be for the purpose of assisting in my care, payment or health care operations including quality initiatives. I understand that Medical Group will own these images. Copies may be available at a reasonable cost. I may revoke or withdraw this consent at any time by giving written notice to my provider. Withdrawal of consent does not affect any information prior to the written notice of withdrawal.

_____**Patient or Parent/Legal Guardian Initials**

ASSIGNMENT OF BENEFITS

I authorize Medical Group to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Medical Group. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to Medical Group to apply to my account, should a balance exist. This assignment will remain in effect until revoked by me in writing.

_____**Patient or Parent/Legal Guardian Initials**

Patient Name_____

NOTICE OF TELEHEALTH/TELEMEDICINE SERVICES

I acknowledge receipt of notice of my rights with respect to telehealth/telemedicine. A copy will be provided upon request.

_____**Patient or Parent/Legal Guardian Initials**

NOTICE OF FINANCIAL POLICY

I acknowledge receipt of and agree to abide by the Financial Policy. The Financial Policy is available to review in the clinic and a copy will be provided upon request.

_____**Patient or Parent/Legal Guardian Initials**

NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices is available to review in the clinic and online at Medical Group's website. A copy will be provided upon request.

_____**Patient or Parent/Legal Guardian Initials**

_____ _____

Signature of Patient or Parent/Legal Guardian **Date**

Please note: If you are a legal guardian or court-appointed representative, you must attach a copy of your legal authorization to represent the patient.

Legal guardian's name	Street address/City/State/Zip	Phone number

NOTICE OF TELEHEALTH/TELEMEDICINE SERVICES

Please read prior to receiving services.

I understand that I have the following rights with respect to telehealth/telemedicine:

1. **Definition of telehealth/telemedicine.** Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable healthcare providers to deliver healthcare services to patients when located at different sites.

2. **Right to care.** I understand that the same standard of care that applies to an in-person visit will apply to a video visit. I understand that I have the right not to participate or decide to stop participating in a video visit and that my refusal will not affect my right to future care or treatment.

3. **Patient information and confidentiality.** I understand that the laws that protect the privacy and confidentiality of health care information also apply to telehealth/telemedicine services. I understand that video, audio, or photographs may be stored with my consent and that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician; therefore, I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, including audio and/or video, may be by electronic transmission.

4. **Communication risk and consent.** I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, of interception, interruption, or distortion due to technical failures. If it is determined that the electronic connection is not adequate, I understand that my healthcare provider or I may discontinue use and make other arrangements to continue the visit by other methods. By signing the registration form (including all forms of digital signature) and providing my mobile number and/or email address within the telehealth platform, I consent to receive SMS/text messages or emails (message and data rates may apply) for the purpose of video visit reminders and/or connection links. I acknowledge that messages may contain protected health information (PHI) and sent via unencrypted means, there is some risk of disclosure or interception, and I may opt-out by removing my mobile number or email address from the applicable account within the telehealth platform. I acknowledge understanding of the Texting Terms and Conditions available online (www.wellmedhealthcare.com/texting-terms).

5. **Insurance and billing.** I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my video visit. I understand that health plan payment policies for video visits may differ from in-person visits.

6. **Complaints.** I understand that I may file a complaint about physicians, as well as other licensees and registrants of the respective state's medical board.

   Texas Medical Board: 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, TX 78768-2018. (attn.: Investigations) or 1-800-201-9353. More information available www.tmb.state.tx.us.
   Florida Health Care Complaints: Department of Health, 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399-3260. Email: MQA.ConsumerServices@flhealth.gov. Fax 850-488-0796. More information available at https://www.floridahealth.gov.
   New Mexico Medical Board: 2055 S. Pacheco Building 400, Santa Fe, NM 87505. Fax: (505) 476-7237. Email: nmbme@state.nm.us. More information available at https://www.nmmb.state.nm.us.

PATIENT FINANCIAL POLICY

Please read prior to receiving services.

Throughout this Financial Policy, "We" and "Us" includes WellMed Medical Group, PA; WellMed Medical Management of Florida, Inc.; and OptumCare Florida Inc.

Payment: If your deductible has not been met or a percentage is your responsibility, payment is expected at the time of service. If you are responsible for any balance due after any insurance claims are processed, the balance will be billed via a statement. There is a $25 charge for returned checks.

Proof of insurance: All patients must complete the patient information form before seeing a clinician. Please notify our office of insurance changes in primary or secondary insurance coverage. We will obtain a copy of your driver's license or state ID and current, valid insurance card. If you do not provide us with the correct insurance information in a timely manner, you may be responsible for the claim's balance. If we are unable to verify/confirm your eligibility, you may be responsible for the charges incurred.

Insurance: We participate in various insurance plans, including Medicare. Before receiving services, you should know your benefits and verify that we are participating providers for your insurance. If you receive service and we are not participating providers or our physician is not listed as your primary care provider with your insurance company, or uninsured payment is due in full at the time of service.

Managed care: All managed care (HMO, PPO, etc.) co-payments are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or surgery without a referral authorization, your insurance plan may deem this as out-of-network or non-covered treatment, and you will be responsible for a larger amount or all the charges. Please ensure you understand what services are covered and are prepared to pay for any service deemed to be non-covered or not authorized by the plan.

Medicare: We participate with the Medicare program and accept the Medicare allowable payment, patient deductible, and/or 20% co-insurance. If you have supplemental insurance (Medigap), please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. In these cases, you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

Medicaid: If you have Medicaid coverage of any kind, please notify us prior to your visit. This is part of your agreement with Medicaid; failure to notify us of Medicaid coverage may result in your fiscal responsibility for services rendered.

Co-payments and deductibles: All co-payments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Please be aware that some or all of the services you receive may be non-covered or considered non-reasonable or not necessary by Medicare or other insurers. A payment is due at the time of service and any remaining balance due will be billed via a statement.

Claims submission: We will submit your claims to your Insurance. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-payment: If your account is past due, you may contact our billing department to make payment arrangements. If not paid, we may begin various collection activities including, but not limited to submitting the past due account to a collection agency.

Automobile accident patients: We may treat established patients for automobile accident care. A claim will be filed with your health insurance plan, or we accept payment as self-pay. We will not accept a letter of protection from an attorney as a guarantee of payment or bill third-party insurance.

Workers' compensation: We do not treat new or established patients for workers' compensation/work injury. Additionally, we do not participate in workers' compensation insurances.

Children of divorced parents: Payment for treatment of minor children rests with the parent who seeks the treatment. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Us.

Fee schedule (charges): Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area.

Statements: We will send a billing statement to the billing address you provide. If you have questions or dispute the balance's validity, contact our business office as soon as possible upon receipt of the statement.